Introduction to Money Follows the Person
March 11, 2008

The Centers for Medicare & Medicaid Services (CMS) Money Follows the Person Rebalancing Demonstration (MFP Demo), created by section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171), supports State efforts to "rebalance" their long-term support systems by offering 5-year competitive grants to States.

Specifically, the demonstration will support State efforts to:

a) Rebalance their long-term support system so that individuals have a choice of where they live and receive services.
b) Transition individuals from institutions who want to live in the community.
c) Promote a strategic approach to implement a system that provides person centered, appropriate, needs based, quality of care and quality of life services and a quality management strategy that ensures the provision of, and improvement of such services in both home and community-based settings and institutions.

The demonstration provides for enhanced federal medical assistance percentage (FMAP) for 12 months for qualified home and community-based services for each person transitioned from an institution to the community during the demonstration period. Eligibility for transition is dependent upon residence in a qualified institution. The State may establish the minimum timeframe for residence between 6 months and two years as required by Section 6071(b)(2)(A) of the DRA. The State must continue to provide community-based services after the 12 month period for as long as the person needs community services and is Medicaid eligible.

Under the demonstration project, the State must propose a system of Medicaid home and community-based care that will be sustained after the demonstration period. States may also propose to enhance the services they will provide during the demonstration period to achieve greater success with transition.

Overview of Maryland MFP Demonstration Programs

The goal of the MFP demonstration in Maryland is to encourage rebalancing by improving the transition process from an institution to community living through increasing outreach and decreasing barriers to transition. New efforts under MFP include peer mentoring, enhanced transition assistance, improved information technology, housing assistance, flexible transition funds, and the addition of waiver services to existing waivers. MFP will collaborate with the Maryland Department of Aging on the Aging and Disability Resource Center initiative, forming a collaborative workgroup with the Mental Hygiene Administration to improve behavioral health services to individuals receiving long-term care, and evaluating and streamlining the Medicaid and waiver eligibility process.

Peer mentors will provide outreach, education, advocacy, and peer support. Peer support will be available for institutional residents and their families. Regional contracts will be offered to create local peer mentoring contractors that will provide these services in

nursing facilities (NFs). Peer mentors may also provide ongoing support during and after the transition.

A statewide Transition Center will be created to provide program education, application assistance, and transition services to NF residents interested in transitioning to the community. This Transition Center will also provide housing assistance to all residents of qualified institutions seeking independent housing. In addition, their staff will monitor and work towards developing housing opportunities for persons with disabilities by collaborating with local and State agencies.

Flexible funds will be offered through the MFP demonstration and administered by the Transition Center to further address barriers to transitioning. These supplemental services include funds for groceries, transportation, and other needed goods and services that could not otherwise be funded by Medicaid.

A web-based tracking system will be created to assist the peer mentors and the Transition Center in tracking and following up with individuals who express an interest in moving to the community. The system will enable the various partners in the transition process to share information and increase collaboration. This new system will interact with the existing Older Adult and Living at Home waiver tracking systems to allow for better communication and a more streamlined process.

The Developmental Disabilities Administration (DDA) has existing Community Placement Teams that will be enhanced to support residents of SRCs as they transition from Maryland's intermediate care facilities for the mentally retarded (ICFs/MR) to the community. These teams will include new staff positions. At the state level, one staff person called an SRC Transition Coordinator will work on systemic barriers to transitioning by identifying the barriers and developing solutions. Two other new positions will be created and titled community placement specialists. These specialists will work on individual transitions and enhance the existing Community Placement Teams that include Regional Office staff, Resource Coordinators that serve as case managers, SRC residents, their families, SRC staff, and the peer mentors. The new community placement specialists will develop relationships with residents, families and SRC staff to facilitate communication and to develop solutions to individual barriers to transition.

In the community, MFP demonstration participants will access services through Maryland's five existing home- and community-based services (HCBS) waiver programs: the Living at Home (LAH) waiver, the Older Adults Waiver (OAW), the Traumatic Brain Injury (TBI) waiver, the Community Pathways (CP) waiver, and the New Directions (ND) waiver. The MFP demonstration will add services to several of the existing waivers to enhance the service package available to individuals who use these programs. Specifically, MFP will add environmental assessments, nutritionist/dietitian services, and home delivered meals to the Living at Home waiver and add transition services to the Older Adults Waiver. The work to add services to the existing waivers will incorporate efforts from each of the partnering agencies including the Developmental

Disabilities Administration, the Department on Aging, and the Mental Hygiene Administration.

The behavioral health workgroup that aims to develop recommendations for better identifying and serving individuals with co-occurring medical and behavioral health needs began meeting in December of 2008. The group split into three sub-groups. One group will focus on community-based service options for residents of Maryland's Institutes for Mental Disease that are over 65 ad Medicaid eligible, another group will focus on serving individuals with brain injury, and another group will focus on co-occurring behavioral health need of individuals transitioning out of group homes. The sub-groups will meet at east monthly, gathering and evaluating information about needs and service options. The group will then develop specific recommendations for improving identification of behavioral health needs and improvements to community-based behavioral health services.

Other collaborative efforts with partners in the demonstration include participation on a workgroup to develop the RFP for the ADRC's website that will include MFP and long-term care information, participation on several of the waiver advisory committees, and increased collaboration with the Division of Eligibility and Waiver services.